

## AUTHORIZATION TO RELEASE INFORMATION

\_\_\_\_\_  
Client Name                      Birth Date                      Social Security Number

I, \_\_\_\_\_ authorize \_\_\_\_\_ to release information to the Department of Health, Division of Health Care Financing; Utah State Hospital; or Disability Determination Services which may be necessary to determine eligibility for medical benefits.

I understand that this authorization will expire on the following date, event, or condition: \_\_\_\_\_. I understand that if I fail to specify an expiration date, this authorization is valid for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization at any time by sending written notification to the Department of Health.

I understand that this information is confidential and will be used only to evaluate my eligibility for Medicaid. Any person or institution that provides this information for these purposes is released from any liability.

**PLEASE NOTE: A PHOTOSTATIC OR FAX COPY OF THIS AUTHORIZATION IS CONSIDERED VALID.**

INFORMATION SOURCE: \_\_\_\_\_

Please verify the following information concerning: \_\_\_\_\_  
Client Name                      Social Security No.

\_\_\_\_\_  
Please return this form to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Case Name \_\_\_\_\_ Case Number \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_